

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-025829

Registration District No.

318

Primary Registration District No. 1003

Registrar's No.

7077

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

FILED JUL 12 1963

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN ST LOUIS

Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY

c. CITY OR TOWN

ST LOUIS

Inside Limits
Yes ☐ No ☐

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION EDGEWATER NURSING HOME

Inside Limits

Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location)

L19 FASSEN ST.

Reside on Farm
Yes ☐ No ☐

3. NAME OF DECEASED
(Type or print)

First

Middle

Last

LENNIE E. DUNSCOMBE

4. DATE OF DEATH

Month

Day

Year

JULY - 7 - 1963

5. SEX

FEMALE

6. COLOR OR RACE

WHITE

7. Married ☐ Never Married ☐
Widowed ☒ Divorced ☐

8. DATE OF BIRTH

2-28-1879

9. AGE (last birthday)

84

IF UNDER 1 YEAR

IF UNDER 24 HR

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY

HOME

11. BIRTHPLACE (City and state or country)

LITTLE ROCK ARK

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13a. FATHER'S NAME

LOUIS MANTLER

13b. MOTHER'S MAIDEN NAME

UNKNOWN

14. NAME OF HUSBAND OR WIFE

WILLIAM DUNSCOMBE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

LEANETTE ROSE

Address

6256 LEMAY BLVD ST LOUIS 26 MO

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

ARTERIO-SCLEROTIC HEART DISEASE

INTERVAL BETWEEN ONSET AND DEATH

2 YRS +

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY
Hour a.m. p.m.
Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐
NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from 6-13-63 to 7-7-63 and last saw her alive on 7-3-63
Death occurred at 5:20 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)

John W. Drake M.D.

22b. ADDRESS

740 S. 4th St. St. Louis

22c. DATE SIGNED

7-8-63

23a. BURIAL, CREMATION, REMOVAL (Specify)

REMOVAL

23b. DATE

JULY-9-1963

23c. NAME OF CEMETERY OR CREMATORY

PARK LAWN Cem.

23d. LOCATION (City, town, or county)

LEMA

(State)

24. FUNERAL DIRECTOR

FEY FUNERAL HOME, MEHLVILLE MO

25. DATE RECD. BY LOCAL REG.

JUL 8 1963

26. REGISTRAR'S SIGNATURE

Edna Smith, M.D.

USE BLACK INK

OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DATE AMENDED

DOCUMENT

BY AFFIDAVIT OF

VS 300
Rev. 4/59

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86

86-0

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

working under my personal supervision.

Signature of Student Embalmer

Signed

Licensed Embalmer No. _____

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license):

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.